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ABSTRACT

This document contains papers delivered at a conference designed to highlight similarities and differences in the situation of the elderly in Sweden and in the United States. The papers are: (1) "Aging and Work" (Sheppard, Berglind); (2) "Services to the Elderly: An Emphasis on the United States" (Hokenstad); (3) "Notes on Services to the Aged in the United States and Sweden" (Sundstrom); (4) "Formal and Informal Support of the Elderly: Selected American Cultural Values and Social Welfare Policy" (Mullins); and (5) "Caring for the Elderly in Sweden and the United States" (Thoreus-Olsson). (CML)

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DISCUSSIONS ABOUT AGING: SWEDEN AND THE UNITED STATES

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CONFERENCE INTRODUCTION

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CONFERENCE INTRODUCTION

S. Åke Lindgren

As Vice-President of the Delegation for Social Research, I am pleased to be invited to organize this workshop together with the School for Social Work at the University of Stockholm. We are very pleased that we have distinguished guests and lecturers from the United States and Sweden. I think that most of the Western societies will be sharing the same problems with an increasing number of elderly people who will remain healthy up until the age of eighty-five and beyond. During the last decades, we had not been aware of this development fully, so we thought of the elderly people as very frail and in need of institutional care, but research in this country and in other countries has shown us that elderly people, like my grandmother and my grandfather, like to lead a normal life like myself, my children and my grandchildren. This means that we have to look to the environment, to housing, to activities when people leave their worklife and go into retirement, so that they can still be active and not always sitting in their homes living quiet inactive lives. On the outskirts of Stockholm, there has been an exposition on housing in Sweden as it will be developed during the next decades. When the Ministers of Social Affairs in the Nordic countries met in 1982, they decided that great emphasis should be put on the housing and living conditions of the elderly.

The meaning of this workshop today is to focus on some topics and to share views between the United States and Sweden. I think the topics that have been chosen for this workshop are excellent. We will be very interested in listening to your lectures. I hope that we have a good

exchange of views between the two cultures and the two different types of societies. We are both wealthy societies and are interested in doing the best for the people who have been responsible for creating the wealth of the society.

Unfortunately, we have noticed in Sweden, particularly in 1985 as we had an election campaign for the Parliament, that there is very tough competition between the two political blocks--the Social Democrats in office and the Conservatives. We from the Ministry of Health and Social Affairs are a bit frightened that if we should have a change between the two blocks it will be a threat to the current welfare system, and to the services provided, particularly for the elderly and the children. In some of the remarks given by the Conservatives, they used examples of the experiences in the United States where you have a quite high degree of private, private-not-for profit, and private for-profit institutions caring for the elderly. We are quite aware of the usefulness of competition between different types of organizations, but at the same time think that the society should take particular responsibility for the elderly and try to give the support they request.

What we hope to get out of the meeting is to find out from the presentations what are the similarities and what are the differences between the two countries and what could explain the differences between the two systems. As I said recently, we would like to listen to your explanations and discuss how we could forsee change in the two societies.

Before the meeting started I talked with some of you from the States, and I said that we are really interested in having an on-going exchange of experiences, views on how to handle problems, and ideas for

interesting areas for research. In Sweden, research is an area which has been given high priority by the present government, and we are pleased that even social research has received more support. We do not have much money, only about thirty-five million Swedish Crowns, which is peanuts in relation to the total research budget but of that budget, during the past few years, we have spent about 6 per cent on social research on the elderly. The Medical Research Council, which is a very wealthy research council, has also spent a lot of money on research on the medical factors related to the aging process. But I think that this area needs more multi-disciplinary studies, and I see that we may have this opportunity to look into opportunities to continue that work and to foster a better understanding between the two sectors.

AGING AND WORK

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Harold L. Sheppard and Hans Berglind

Sheppard: This event is important to the International Exchange Center on Gerontology (IECG) at the University of South Florida, because it is a perfect example of the kinds of activities we are trying to get started, through the Center, with overseas individuals and organizations. The IECG is a consortium of all the public universities in the state of Florida plus two private universities, 11 in total. One of its key purposes is to find out what we might learn from other countries vis à vis practices and policies regarding aging for the state of Florida. You may or may not know it, but Florida has the highest percentage of elderly of all the states in the United States, 17 or 18 percent if you start counting at age 65, which is roughly the same percentage in Sweden. In some parts of the state there are many sections which have as much as 35, 40 and 45 percent of the population 65 and over. So you can see, many of us in Florida believe -- the State Legislature, the Governor and the Board of Regents for the university system -- that there is much to learn, and that we have room for improvement. One of the instruments created to implement that belief is the International Exchange Center.

Berglind: I want to say a few things about the labor force participation rates in Sweden among older people. I have been looking at the changes that have taken place, for example, in different age groups, in the relative number of people that are in the labor force. What we find in these studies is that in all age groups below the age of 65, we would find an increase in the degree of participation for women and a decrease for men, and the decrease is higher in the highest age

brackets. For example, between 1965 and 1980 there was a decrease of 8 percent in the number of older men in the age group 45-64 that were employed, while among women there was an increase in this age group. There has been a decrease for women of about 7 percent in participation. They started at 11 percent and went down to 4 percent between 1965-80. For men there has been a decrease of 23 percent from 37 percent to 14 percent. So, it is becoming more and more unusual that people above the age of 65 continue to work. Partly this has to do with the lowering of the pension age from 67 to 65 in 1976, but this doesn't explain the whole of it. Anyway, there are no legal obligations for people to leave at the age of 65 even if that is something that is often written about in the contract with the union.

Sheppard: The same changes have been happening in the United States despite the fact that we don't have any official policy of earlier and earlier retirement or greater opportunities for retirement. We should go into why we get the same trends despite the fact that there is a law in the United States that prohibits age discrimination in employment until age 70, and so on. The law is called the Age Discrimination in Employment Act (ADEA), originally passed in 1967 which prohibited compulsory retirement from age 40 until age 65. But the amendments of 1978 raised it from 65 to 70. There are now efforts on the part of some legislators to eliminate any retirement age and there is a great deal of concern about that possibility on the part of some segments of the economy.* What it really means is that an employer cannot force a worker to retire for reasons of age until the age of 70. In certain states like Florida and California there is no upper age at all. I

*In October, 1986, the law (Age Discrimination Act) was amended to abolish any upper age of mandatory retirement.

think that is very important to know for the purposes of policy research and policy evaluation. That is, the world did not come to an end in those two states. The sky is not falling despite the fact that in Florida and California there is no age that public or private employers can use as a basis for making a person leave the place of employment. There are other provisions of the Act which are not relevant for our purposes.

I think the importance of the law, at least in my point of view, is that it is a matter of civil rights and not primarily a matter of allowing more and more people to work beyond a certain age because they want to. There are some people who distort the law and think it means <u>forcing</u> people to work until they are 70, but that is the result of poor public education about the purpose of the law. Very many people don't even know of its existence. Nevertheless, every year witnesses an increase in the number of age discrimination complaints filed. The word is spreading. One final point on that: the level of complaints is partially a function of economic conditions. When you get high unemployment, you are going to see more complaints filed by people 40 and over.

But to return to the point being made by Professor Berglind, in the United States, too, there is a trend toward declining labor force participation starting as young as age 35, but especially among men. Indeed, until about age 55, the participation rate among women has been increasing.

<u>Berglind</u>: We may think that when we study the labor market statistics in Sweden that we are facing a unique development, but should be quite clear that we are facing an international development, at least in the

industrialized world. We can go into the reasons later, perhaps. It means that people in the higher age brackets are gainfully employed to a lesser extent, and that is specifically true of the men. The women have been moving into the labor market but very often in part-time work.

I recently looked at the increase in part-time work among men and women in the age group 60-64. Before 1976, for example, only 10 percent of the employed men worked part-time. By 1982 it had increased to 25 percent, from 10 percent to 25 percent in six years and for women there has also been an increase in part-time work. In 1982, almost 60 percent of women between 60 and 65 were working part-time. That is higher than for employed women as a whole, because among all employed women, 50 percent work part-time. So the increase in part-time work has something to do with the partial pension system that was introduced. This explains why it had increased among the men. On the whole, there had been a trend over a longer period of time, at least of increasing part-time work. Is that something you have noticed as similar in the United States?

Sheppard: I am not totally clear on all the statistics but when you start talking about people 60 or 65 or older who are still in the labor force, the overwhelming majority are in part-time work. But I don't want to rule out the possibility that a lot of part-time workers are still looking for full-time work and in this current period cannot find it. I'm thinking now of the group that is old but are not yet of pension age. They still need full-time work. A very large part of the growth of employment in the United States has been the growth in part-time work because the factories and offices still don't need enough full-time workers. But there also is a great popularity of part-time

work. One study was done on the people in their 50's still working in 1981 and a few questions were used to identify of what I called "the candidates for part-time work." Forty-three percent said they would like to "retire" but continue working on a part-time basis. The challenge now is to create those kinds of opportunities. There are very few companies that are doing that but one of the best examples is Travelers Life Insurance Group, which conducted a survey among its people age 50 to 55 or so and found that about 80 percent did not want to retire full-time but instead wanted to continue with Travelers on a part-time basis. The company's previous rules made that difficult but the Board of Directors changed the rules and made it possible. By that I mean, they were allowed to get their full pension and continue to work but for no more than 1000 hours a year, with no penalty from their pension, whereas before the policy change they would have lost part of or all of their pension. So, it has been very successful and many of us are trying to get other companies to adopt such a policy.

It is strange to me that the company never thought of this as an advantage until some top executives became interested in aging in general and older workers in particular. They began to discover the economic advantages to continuing to keep these people. Before, they would retire these full time employees and then go to a private or public employment service agency to find replacements on a part-time basis; they paid the cost of looking for such workers and the price of the learning curve for these new employees to learn the jobs that these other people already knew.

Berglind: To go back to the question of the changes in the employment patterns, parallel with that we had an increase in Sweden in early

retirement pensions. So, this is what we refer to as Earlier Retirement Pensions; I guess it is somewhat different from the term in English or American! We include in that, for example, the disability pension and the basic requirement to get a disability pension is that your work capacity is reduced by at least 50 percent. And then, from the age of 60 you can also get the Premature Early Retirement Pensions for reasons other than disability, one reason being that you have difficulties in finding a job, or that you have been long-term unemployed, for example. It is the same kind of pension as that received by old-age pensioners. It consists of two parts. One part, i.e., the basic pension, is paid regardless of previous income. The other part comes from the supplementary pension, or as we call it, the ATP pension. The size of the ATP pensions depends on how long you have worked.

Sheppard: I would like to hear a discussion about the word "prematurely" in terms of its value connotation.

Berglind: Let us look at Figure 1. In this you can see the increase for the age group 60-64: Only 10 percent in 1967 had this early retirement pension but in the beginning of the 80's it was something like 65 percent. This partly is explained by changes in legislation which makes it easier in that age group to get a pension. But the increase has also taken place in the age group 50 to 59. It also has doubled in that age group.

Sheppard: How do you explain that if the partial pension doesn't cover that age group? The question about the 50 to 59 age group is not a change in legislation.

Berglind: No, it is actually not. So it has to do with the fact that rules have been applied in a more liberal way, I suppose. That is one

possibility. Another possibility is that people get more and more disabled in that age group, so that the deterioration of the health of the 50 to 59 year-old people may occur, which I don't think is very plausible. But this has been a matter of debate in Sweden because there are people who have a background in economics who would say this has to do with the fact that people prefer to retire. The increase in the pension benefits has been at a higher rate than the wages and salaries. If your work capacity is reduced by 50 percent or more, then you get a disability pension. Does the definition of disability become more liberal? It looks like that is the case, and then comes the question "Why?". Is it because the people who get this disability pension are so eager to retire, or is it that they had to retire because it is getting more and more difficult to find a job?

Sheppard: Is it also because of a more liberal provision or because of the nature of the job is so negative that it might discourage people from wanting to stay on the job?

Berglind: Yes, you have also had in the United States an increase in premature retirement

Sheppard: Basically, the number of people retiring between the ages of 62 through age 64 has been increasing. About 75 percent of all people in that age group have begun to take early retirement benefits through Social Security. But that doesn't mean that they retire totally. Among those receiving Social Security benefits at age 62, which is the earliest you can get them, 19 percent of the men are still working and about 17 percent of women. In the age group 63-64, 26 percent of the men and about 29 percent of the women are still working. The unmarried women have the highest percentage still working from 62 onward, and the

group with the lowest percentage still working are married women. The high percentage of unmarried women still working and still getting a social security pension is an indication of the problems of unmarried women in the economy of at least the United States.

Berglind: I want to say a few more words about this age group 60 to 64 because I just saw some figures on the number of people who get early retirement pension for what is called labor market reasons. Sometimes it is very hard to draw a distinction, but in the statistics on pension receipts on the grounds of lack of employment, the figures look like those in Figure 2. Judging from the studies that I have been involved in before, I think it probably is correlated to the local labor market.

Sheppard: Very few studies are done in the United States on the characteristics of the labor market in relation to the early retirement issue, but the biggest source of data is the National Longitudinal Survey (Sheppard, 1977). Five thousand men 45 to 59 were interviewed for a ten year period starting in 1966. I have the data from 1966 to 1973 and found that, especially for the men, the higher the unemployment rate in the local area, either at the time of the beginning of the survey or a few years before 1973, the higher the percentage of men retiring before age 65. Economic opportunity therefore plays a very important role and not just the pension or expected pension level, and not just illness. The subsample I studied was restricted to only those men who had no health problems as of 1966. It was not a question of health being a variable or a factor in the early retirement "decision". Those of us who are concerned about "premature" retirement have to be concerned, then, about the general economic conditions of the local or national economy.

Berglind: So, what you are saying now seems to support the view that this development could at least partly be explained by the fact that there has been growing unemployment.

Sheppard: Yes, one of the points I wanted to make is that while we don't have all the wonderful early retirement opportunities that a lot of countries have, nevertheless, the market mechanism serves as a substitute for them - for good or bad.

Berglind: Well, there is another question related to this, I suppose. You mentioned that we have provisions for people who want to retire. We have the Partial Pension Scheme which means that from the age of 60 you can retire part time with a very slightly reduced pension relative to your earlier earnings, and you have unemployment benefits which means that you can, if you are in the higher age brackets, get 450 days of compensation from your unemployment fund.

One argument that you can hear now and then is that if there are such great possibilities to retire or get unemployment benefits and so forth, maybe the decline in labor force participation is explained by that. I mean the fact that you can get so much money from the welfare state that you decide, why continue working? "I am maybe as well off if I am not working". If that is the case, I suppose that in the United States, then, the philosophy is that if you had a hard time not working, more people will be in the labor force.

Sheppard: That is true. More people will be in the labor force but it doesn't mean they are employed. Anybody looking for a job but not with one, and anybody with a job, are called part of the labor force but not the discouraged workers. They are not included. I am convinced that there are lots of people who, if they were getting less unemployment

insurance, would do more to get a job but I am convinced, also, that that is not the majority. I haven't done empirical research on this issue for about 15 years but, when I did do it, I found that those who had not exhausted their unemployment insurance were still having problems getting a job. Most of them were looking strenuously or had looked very much and over time they did get discouraged. That study included everybody who even stopped looking because of discouragement, although legally they are not called unemployed. What we need on this issue are empirical studies, not armchair reasoning from an ideological point of view, to see what factors actually make or break continued job-seeking and job-finding success.

I think that is another basic reason for my excitement about this particular meeting today. I hope we move on to get out of our armchairs to support and conduct research that can answer some of these policy issues or at least shed more light and less darkness.

Berglind: Before we get out of our armchairs for lunch, I think it would be very good, since you have such a thorough experience of the situation of workers that are in the situation that we have been talking about, if you could tell us a little more about that before we take a lunch break?

Sheppard: The job hunt study was done in an area in Pennsylvania with a high unemployment rate in the early 1960's. We had access to people who had applied for unemployment insurance. We did not know if they were employed or re-employed or still unemployed before we conducted an intensive interview concerning what they actually did to look for work. Also, we did some interviews of employers to get both sides and there were some very basic findings there about what job seeking techniques

were most successful. Just to give one example, in the labor economics literature, the economists would say that workers are very irrational or not rational in looking for a job, that they should concentrate only on those companies that announce they have openings. Why should they go to a company that has no announcement about vacancies? Well, we found that those workers who went from company to company asking if there were job openings, and who did not restrict themselves only to those companies that advertised openings had a higher job-finding success rate than those who only went to those companies who announce they have openings! That was fascinating.

To give one obvious explanation (it is only obvious after you have given the answer): the more companies you go to the greater the probabilities that you are going to find a job; it is a matter of mathematics and probability theory. And that is what we found. If a worker restricted his job search only to companies advertising that they have vacancies, he naturally goes to fewer companies than workers <u>not</u> restricting which companies they go to! There were also some social-psychological characteristics of workers that were included in the study. For example, <u>job interview anxiety</u>: the higher the anxiety, the longer it took for workers to start looking for a job, and the fewer companies they went to. On the other side, we had some measures of <u>achievement motivation</u> (you may know of that literature) and we found that those with higher achievement motivation started earlier and went to more companies and guess what? They had a higher job-finding success rate. The challenge from an applied point of view is 1) how do we reduce job interview anxiety, and 2) can we and how do we raise achievement motivation at the micro-level?

I mentioned today that we have to have a national economic policy to increase demand for employment, and at the micro-individual level, to work with the individual to change his or her job-seeking behavior to increase the probability of finding jobs.

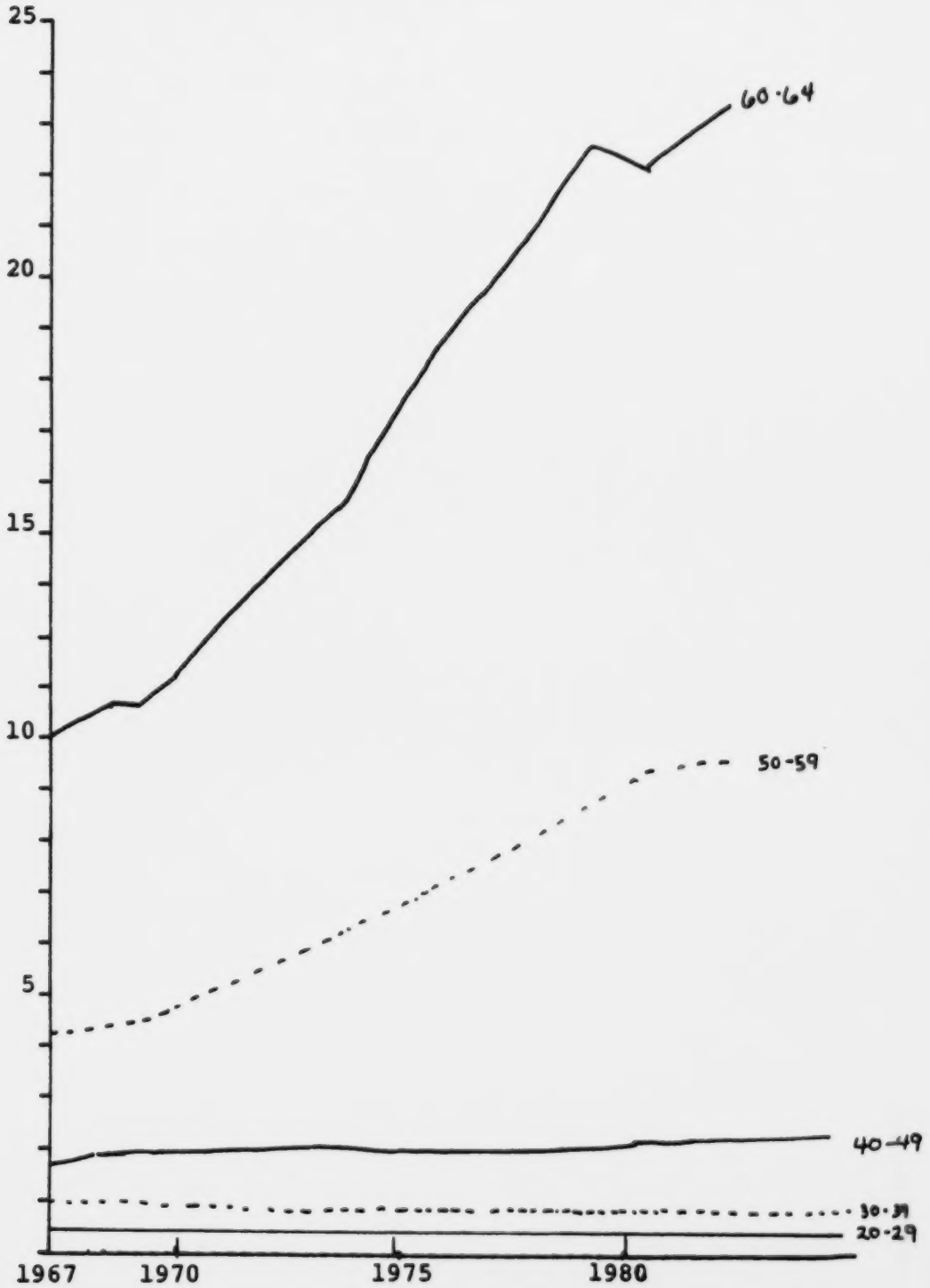

Figure 1 Relative number of prematurely retired in Sweden as a percent of population in different age groups.

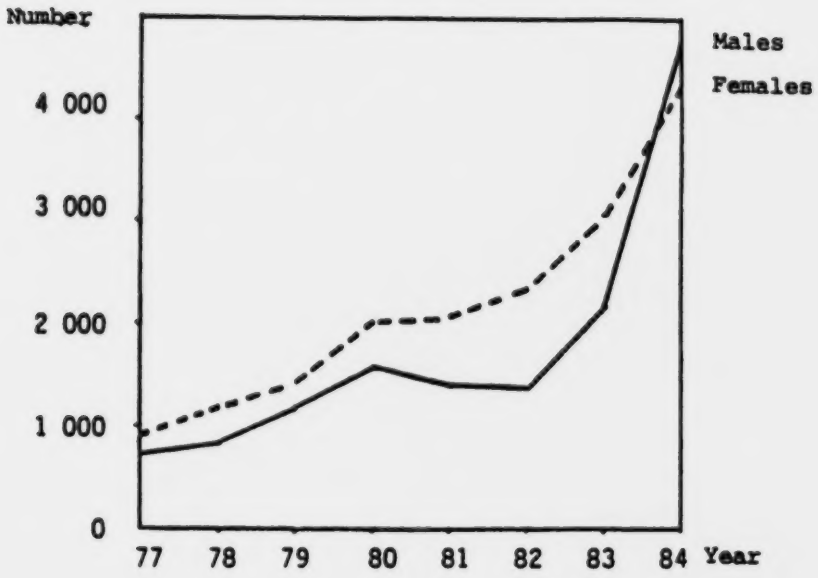

Figure 2. Yearly number of premature retirement pensions awarded "for labor market reasons" 1977-84.
Source: Social Security Administration (RFV).

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SERVICES TO THE ELDERLY:
AN EMPHASIS ON THE UNITED STATES

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SERVICES TO THE ELDERLY

Professor Merl K. Hokenstad

INTRODUCTION

Today we have an important topic of concern on both sides of the Atlantic Ocean. It is a maximum topic in terms of the issues involved and we have minimum time to address these issues. Thus, consequently I will attempt, in my remarks, to cover specific issues and concerns we have in the field of services to the aging. There will be an opportunity later to engage in a more detailed discussion of these issues, and hopefully at that time, questions can be raised as well as issues explored in detail.

First of all, I would like to point out the principles of service provision for the elderly are similar in Sweden and the United States. For example, all industrialized countries emphasize the desirability of maintaining the elderly in their own homes. This is a goal, toward which we are all working: to keep elderly out of institutions as long as possible. Principles such as this are well expounded on both sides of the Atlantic; however, there are great differences in our attempts to implement these principles.

Today, I would like to give some attention to the differences in the service systems. I will focus on the systems of service provision and service delivery rather than try to detail individual services to the elderly. This includes documentation of some differences in terms of the resources provided. For example, Sweden has twenty times the proportion of home help to the elderly in the society than that which

exists in the United States. Sweden has committed more resources to dealing with this problem about which we are all concerned.

Also, we need to compare how services are organized, the manner in which they most effectively are delivered to the people needing help and to what extent they are utilized adequately. Consequently, I will suggest some common issues in the delivery of services and approaches to dealing with those issues. For example, the coordination of health care and social services is an issue for both countries. Sweden is working on the problem of how best to link the health care sector with the social services sector in providing the best possible services to older adults in this society. The United States is also struggling with this issue. Finally, I would like to recommend some needed research in the area of service provision, e.g., research about factors which influence the utilization of social services. How can we find out more about how people might most effectively use the services that are available?

PRINCIPLES OF SERVICE PROVISION FOR THE ELDERLY

First, what are the principles of service provision for the elderly? As you know, the Swedish principles are well articulated in the Social Services Act and in the New Health Care Act.

- Normalization. Old people should be given an opportunity to live in as normal a setting as possible.
- Influence and participation. Old people should have an opportunity to participate in society as a whole.
- Self-determination. Old people should have involvement and options in life decisions.

These are obviously good principles and they provide a basis for the formulation of Swedish social policy.

The United States has similar principles and these are also articulated in our social service legislation. The Older Americans Act which was passed in 1965 states that services provided at the local level should enable older adults to maintain maximum independence. The Public Social Services Act (Title XX of the Social Security Act) aims at achieving and maintaining self-sufficiency including reduction and prevention of dependency and institutionalization. These principles are similar in intent to those in Sweden, i.e., they aim at preventing or reducing institutionalization by providing community-based care, home-based care or other forms of less extensive care.

So the goals are good and the goals are similar but what about the mechanisms for implementation? The service systems for the elderly in Sweden and the United States have major differences. Not to belabor the Swedish system which is obviously well-known to you, but it is basically a public, universal, system of service provision placing emphasis on common needs of all citizens and recognizing problems as societal problems requiring societal action. Consequently, the basic pension program plus the supplemental pension provides an adequate replacement income for time of retirement, and in the same sense community service and home care programs guarantee that no older adult will be forced into institutional care against his or her own will.

SERVICE PROVISION FOR THE ELDERLY IN THE UNITED STATES

The United States has a service system based on similar principles but organized in a very different way. In the United States we provide

services for certain categories of people and certain categories of problems so we have a categorical service system. Some programs for the elderly specify older people as a target group. The program and the legislation are aimed, totally at older people, e.g., the Older Americans Act. Other programs which affect the elderly are aimed at certain needs such as the problem of poverty, and thus are directed only at those older people who are poor.

We currently have a major policy issue of age-based versus needs-based programs in the United States. We have the added dilemma that in many cases older people must prove that they are poor before many services can be provided. This categorical system of service provision results in an overlapping, fragmented and often inadequate set of services which vary from location to location. Old age is looked upon as an individual problem rather than a societal issue and there is no overall policy relating to older adults.

For example, the Medicare program in the United States is a health insurance program that covers all older people in the society. It is the only health insurance program of its kind since we have no universal health insurance such as you do in Sweden. There is also the Older Americans Act which provides services for all people sixty years and older. Other programs require income tests and qualifications. While the Medicare program provides help for acute illness in acute care facilities and nursing homes, it does not provide funds for actual long-term care. The only way an older adult can receive long-term care after running out of personal resources is to apply for another type of program. This is Medicaid. Eligibility for this program rests on a means test requiring the older adult to show that he or she is poor.

Consequently we have a system where many people who have been independent all of their lives are required to use up all of their resources, including selling their house to qualify for Medicaid. That hardly creates independence, it creates dependence. Public social services programs provide many services to the aged but the funding is limited for a wide variety of services and each of the fifty states determines what services will be provided. Consequently, we have wide variation in service provision -- in some communities there are very comprehensive services and in other communities huge gaps within the service system.

These then are major problems of service provision for the elderly in the United States. We do have some strong programs that are provided on many different levels. They include programs that are provided by the government (public programs), programs that are provided by voluntary non-profit agencies (incorporated agencies governed through a voluntary board of directors) and an increasing number of programs provided by the profit-making sector in the country. There is wide variation in service provision and in many cases extensive services and considerable funds spent on services. However, the system many times does not operate as a functional whole, and services are not well coordinated.

ISSUES IN THE DELIVERY OF SERVICE

With this background, let me move on to identify a few issues in the delivery of services which are of interest to both Sweden and the United States in spite of the differences in the service system. First is how to implement the goal of maintaining the elderly in their own

homes. Sweden has extensive provision of home health care and home help, yet there is still concern that the elderly leave home and enter into institutions too soon. Consequently, Sweden has attempted to deal with this problem, particularly through the better coordination of the health care and social service sectors. In speaking with the staff from the Swedish Planning and Rationalization Institute (SPRI) about health care and social services, I learned that there is considerable concern about the increasing number of elderly people on the waiting lists, no empty beds in nursing homes, and a shortage of places in service homes. As a result, in the communities of Sundsvall and Vetlanda there has been an attempt to develop an action plan including the interdisciplinary assessment of health conditions and social situations of older people. This includes bringing together the service providers in these two service areas to make a better assessment -- an interdisciplinary assessment of needs. They have found, through this action plan, success in decreasing the waiting list and decreasing the number of people going into institutional care in these Swedish communities.

In the United States we have a similar problem of coordination between the health care system and the social service system. We also have a number of action projects such as those of the Benjamin Rose Institute in Cleveland, where social workers and nurses working together are providing effective home care in a demonstration project. This demonstration project also has had the result of keeping older adults out of institutions for a longer period of time, and it is being studied and evaluated for possible utilization elsewhere. There are some interesting developments going on in both countries in terms of the coordination of services, particularly the coordination of health care

services and social services. While we in the United States can learn from Sweden and SPRI, it also may be possible for Sweden to learn from some of the demonstration projects in which we are engaged in the United States. Our demonstration projects are making much more use of social workers as home help supervisors and coordinators of the home help service than you are in Sweden. Appropriate roles for the social worker is another issue where there should be comparison and communication.

VOLUNTEER OPPORTUNITIES FOR OLDER PEOPLE

Another area which merits attention is the better integration of older adults into society. Later also, we will hear much more about the work component of this, including possibilities of employment and income earned from employment. But the aspect that I would like to focus on here is volunteer services and volunteer opportunities for older adults. This is one area in which the United States has made considerable progress through developing an extensive network of volunteer opportunities for older people. Volunteer opportunities allow older people to remain active in service to each other and to the community. Examples of volunteerism range from organizational representation in senior citizens groups, to friendly visiting of other older people who are isolated in their own homes, to the foster grandparents program with older people taking responsibility for the care of children.

Sweden also has volunteer programs for older people as I have learned. But the United States has engaged in much more extensive organization of volunteer programs. For example, in Cleveland there is a Volunteer Action Center, an agency that focuses on trying to match volunteers with situations where they can be helpful. Organized

programs such as the Retired Seniors Volunteer Program (RSVP) which makes use of the expertise and the experiences which older people bring to the society thus benefitting the society as will as benefitting the individual older adult.

You might say that this reflects a difference in cultures and the uniqueness of the American emphasis on volunteerism which has negative as well as positive aspects. However, it is interesting to note that a 1983 Swedish study initiated by a government committee which studied the work possibilities for the aged found that 30 percent of those older adults who were interviewed said they would be interested in working after retirement in child or old-age care. And among the 30 percent that said they would be interested in working, 90 percent said they would like to do it as volunteers and not for an income. Now there are other issues to be considered such as work opportunities for older people with an income. I will leave that to other experts. Still the volunteer programs in the United States might provide useful examples for Sweden.

TRAINING FOR PROFESSIONAL SERVICE AND RESEARCH IN GERONTOLOGY

Finally, I would like to just touch on training for professional service and research in gerontology. In the United States a major emphasis is now being placed on professional training programs which provide knowledge about older people, their functioning, their problems, and their roles within the society. Additionally skills are developed for working with older people so that normalization and participation can be maximized. This training for doctors in geriatric medicine and for nurses in gerontological nursing and in particular for social

workers has provided a growing cadre of professionals with considerable knowledge about aging, the aging process, the senior citizens themselves and the service network for seniors. It has become a growing specialty in social work, not just in terms of training caseworkers, but also in the training of resource coordinators and advocates who help older people to effectively use available resources in health and housing as well as social services, and who help make resources available and accessible to older people.

Programs in the United States also are preparing researchers from various disciplines to provide more knowledge about older people. There have been a number of research institutes established throughout the country which engage in interdisciplinary research. These institutes bring together professionals from many different disciplines to look at the problems of the elderly and more particularly the services for the elderly and how they can be more effectively used. There is an international need for increased training for both service providers and researchers in the field of gerontology. I am very pleased that Stockholm University is taking the lead in providing some of this education at the present time. Still as you talk about what might be done in Sweden where you have such an excellent service and comprehensive service system, one of the places which might be examined is the training of and preparation of the professionals who will work in that system so that that system can function in the most effective manner. A national institute of gerontology as a focal point for training and research in the field of gerontology might be worth consideration by the National Committee for Social Research and other

funding bodies cooperating with the universities and other researchers in this country.

RESEARCH IN SERVICE PROVISION FOR THE ELDERLY

To briefly indicate the research needed in service provision for the elderly, there is a great need for comparative studies. The United States has learned much from studies of Swedish labor market policies, social welfare policy, pension policy, social care policy. We have gained a great deal of knowledge from you. So, too, can both countries learn from comparative studies of service provision for older adults. I would like to suggest the consideration of variety of studies. These included comparative studies in the organization and delivery of social services; ways in which health care and social services can better be provided through coordination of the service sectors and collaboration of service providers; ways in which different countries can overcome obstacles to effective delivery of social services dthrough social policy, through programming and also through teamwork in service delivery. Finally, I would suggest comparative studies of the factors involved in the effective use of services by older people.

In conclusion, I would say that both countries have many problems to solve and issues to be resolved. In some ways Sweden is in a better position than the United States because you have a more comprehensive and universal system of service provision and a better foundation of social policy. But you, as well as we, now need to concentrate on both research and demonstration projects in these areas of service delivery so that you make certain that your service system operates at peak effectiveness.

NOTES ON SERVICES TO THE AGED IN THE UNITED STATES AND SWEDEN

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INTRODUCTION

Service derives from serving -- there is someone assumed to be served and someone assumed to be able to choose, as well. Service and freedom of choice are intertwined concepts. These ideas will direct my short presentation of services in the United States and Sweden.

The provision of any type of utilities can be assessed at various levels. I will first approach the level of costs, then different types of services and finally the consequences that may result from relative cut-backs in these programs (visible already in Sweden with the home help service) (Daatland & Sundstrom, 1985).

LEVELS OF COST: OPEN VS. CLOSED CARE

Social programs cost money; resources spent give an indication of the public's ambitions. In both the United States and Sweden real costs for health care and old age care have risen tremendously in recent years. Of course, this is also true of social costs at large, as shown in Figure 1. In the last few years the Swedish trend has been broken -- as it had to, sooner or later. The American trend, also seen in Figure 1, was much more modest.

Even if it is recognized that only part of social costs are directed to the aged, the single most important item in any one country's social costs are old age pensions (and other pensions), usually making up about one-fourth or one-third of the total social costs. Figure 2 shows the Swedish trend from 1960-1981. Apart from the impressive expansion of public costs, one notes that the relationship

between the "ingredients" has not changed noticeably over the past two decades.

Notwithstanding the growth of open forms of care, the immense rise of costs within closed care has maintained the balance: every year from 1965 to 1982 about one-fifth of the costs for old age care goes to open care (Spri, 1983). I have not taken the trouble to calculate measures of productivity within the home help system -- the most important form of open care -- but the evidence is that it is rather like the one for closed health care. In large part, this means better care, e.g., higher staff-patient ratios, but also improved working conditions. Up until 1975, municipalities paid only for home help hours actually worked in a client's home. After the introduction of part- and full-time employment, only 60-80 percent of the hours produced are real help provided in a client's home. The rest is paid transportation time, vacation and training, etc.

Only if one takes the rhetoric about the importance of open care at face value can one be shocked by the relative inertia of the system and difficulties for new policies to make themselves felt. On the other hand, this was less of a problem as long as both sectors were expanding. After all, open care made some very real advances during this period. In a situation of restrictions, it all becomes very different.

There is, for example, the worrying tendency that Swedish counties that provide little of the one kind of care (closed) do <u>not</u> instead give more of the other (open). On the contrary, counties that provide badly in one field often provide badly in another as well, and these patterns are often quite stable over decades (Daatland & Sundstrom, 1985).

It is much more difficult to estimate the development of costs for old age care in the United States, with its widely scattered providers, paid and non-paid, statutory and voluntary, etc. Nevertheless, my impression is that the same type of emphasis on closed care prevails there too. Policies to improve open care are seldom given adequate funding, and the mixture between different types of providers may even be counterproductive.

One example is the voluntary organization Visiting Nurses' Association (VNA), that exists in most large cities and is joined by a rather loose network. This organization served previously both poor and well-to-do clients; the fees from the latter off-setting "losses" incurred in serving the former at reduced or no costs. In the last years, rapid growth of competing, profit-making health care providers catering solely to the affluent strata of the population has eroded the market for VNA and thereby made it more difficult also to serve the poor. This is a parallel of Titmuss' example from blood donorship. Co-existence of paid ("egoistic") and non-paid ("altruistic") types of provision may drive the latter out of business or prompt public provision of a second rate system for the poor. Interestingly, "maturing" of the welfare state may also create market "copies" of what is publicly provided. Profit-making construction companies now build private "service-houses" in Sweden, as does the nationwide building cooperative movement. Often these edifices have a nicer setting than the public ones, but are otherwise similar (and the American counterparts).

Opinion polls indicate that there is a considerable interest for these solutions among middle class persons (Sundstrom, 1984a). Of

course, access is money, rather than need and it is uncertain whether these private undertakings can provide the service and care needed in the long run by those living there. It is quite possible that public care has to "lift off" some cases at a later stage (and/or subsidize their rents) which would enable the private establishments to earn the "easy" money at the taxpayer's expense, much in the same way that has been reported from the American nursing home industry.

SUPPLY AND USE OF SERVICES

Having looked at costs already, one may turn to real rates of supply of closed care and the use of it. Figure 3 shows coverage ratios, indicating the availability of nursing home care for persons 80+ in both Sweden and the United States. The most striking aspect of the diagram is the decline in Sweden and the uniform increase in the United States, now approaching the Swedish level. The Swedish decline is probably the outcome of the unsophisticated application of places (beds) 1,000 persons 70+ as a bench-mark for building ambitions in counties. These rates are stable, but they disregard the disproportionate growth among the old-old, and this discrepancy tends to grow progressively worse towards the turn of the century (Brevik, 1984). The reasons for the rising American rate are unclear since the establishment of a nursing home is surrounded by much more red tape and licensing in the United States than Sweden. On the other hand, it is also a much more profitable undertaking in the United States than in Sweden.

Looking at real rates of institutionalization, it is perplexing that Sweden has rather high rates, higher than Norway, for example, which provides much less coverage of home help than does Sweden. This is indicated in Table 1, which shows only a very slight decline in the

Swedish rate, that is more than offset if old people living in service-houses are included (up from 28 percent of the 80+ in 1975 to 30 percent in 1982) (Daatland & Sundstrom, 1985).

Comparing census figures on living arrangements among the aged in Sweden and the United States, one finds rather small differences in the proportions that are registered as living in institutions and the like. The somewhat lower Swedish figures may be due partly to the practice of old people in nursing homes of the medical type to retain their old dwelling for some time (49 percent of the patients in long-term care units in 1975), and therefore are formally still "living" there. As Table 1 shows, patient counts and surveys give higher figures. Another indicator of the possibilities for old people to lead independent lives, is the proportion that live totally alone. This amounted, as shown in Table 2, in 1975 to 27 percent in the United States, and to 41 percent in Sweden.

Among all old persons (65+) a stable minority of approximately 5-6 percent live in institutions in most Western countries. This hides the fact that many more will <u>eventually</u> end up there. No longitudinal study has so far assessed the real long-term rates, but a Swedish study showed 15 percent to have entered a nursing home between 67 and 80, while no more than 2-5 percent lived there at any single time during the study of the cohort (Samuelsson & Sundstrom, 1986). It is important also to recognize that most of the residents in these institutions in both countries are poor, working-class or socially-disadvantaged persons. The never-married, childless, and long-term ill are over-represented with many having led isolated lives before they entered the nursing home. Policies that stress that old people should stay in their homes

may not always be the best for the persons concerned, even if it may be more beneficial for taxpayers.

The Swedish study referred to above also showed that half of those entering a nursing-home had never received a single hour of home help, and a quarter or more could have managed longer at home, had they received and accepted (some had declined offers) adequate help and support (Samuelsson & Sundstrom, 1986; Thorslund, 1981).

Longitudinal studies of the use of informal and formal support are lacking also. Evidence suggests, however, that the "turnover" is a third of the recipients yearly. However, the flux is less if one looks at it from the recipient's side. Most old people never utilize home help services, and die or go to a nursing home after receiving help only from their family (if they have one)(Samuelsson & Sundstrom, 1986).

CONSEQUENCES OF CUTBACKS

This is a grim picture of old age care in a welfare society, and it is not anticipated the picture will be brighter in the future. As seen in Figure 4, the coverage ratio of the home help service has been on the decline for some years. For many years about 20 percent of the aged received home help, and 3 out of 10 elderly households, a proportion that now is regressing. However, it is hard to judge how serious this is since, for example, the home help service sharpens its focus on the very needy, cutting back on cleaning once every second week. At any rate, coverage is certainly much higher than in the United States, where the corresponding proportion usually is about 1.3 percent. An exception is Massachusetts, with 8 percent of the 70+ in 1980 (rising from barely 3 percent in 1976), the same level as in Britain (Branch & Stuart, 1984). A decisive difference with the European pattern is the focus on

low-income elderly (eligibility criteria). In Britain and in Sweden home help recipients show exactly the same socio-economic profile as other old people (Sundstrom, 1985). Thus, the tendency is for the European pattern to be based on citizenship, while the American pattern is based on poor-relief.

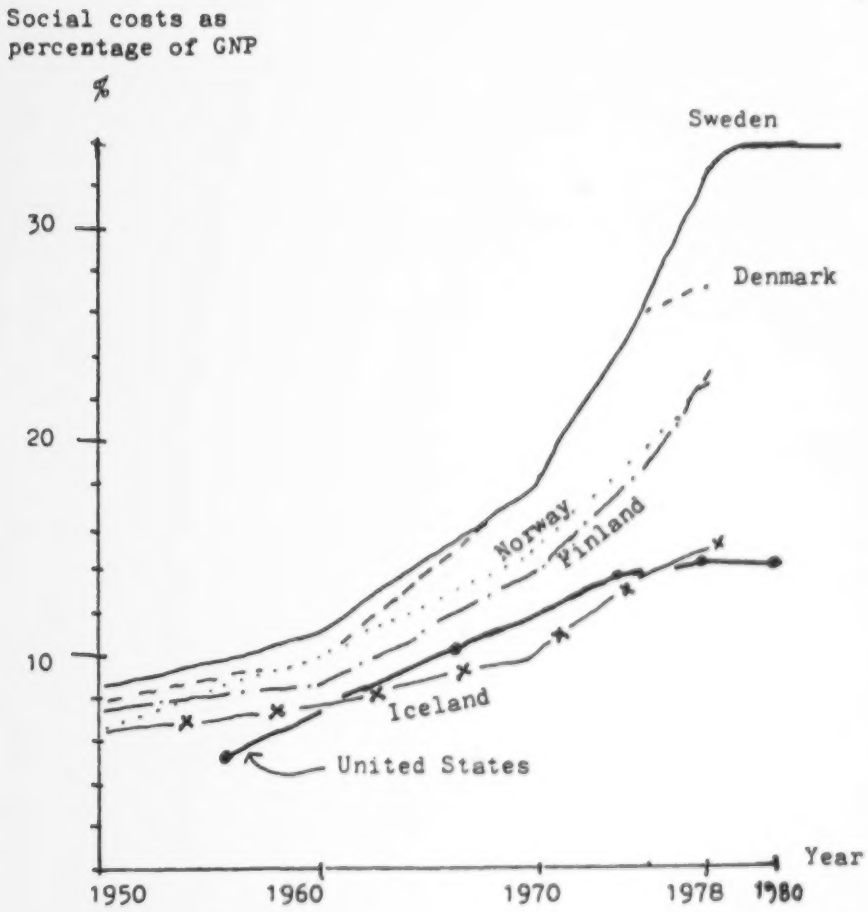
A consequence of cutbacks in the service with low visibility may be that services will primarily be given to persons who lack other types of support. This is quite clear in the British and American (e.g., Massachusetts) systems, and much more so than in the Swedish systems, so far. Cutbacks clearly mean much greater burdens on the informal system of care.

Other types of services to the aged than home help are of much less significance. All Swedish municipalities offer a wide range of services like transportation (used by 7 percent of the aged), chiropody and so forth. However, a minority uses any type of service (the highest figure refers to chiropody, 11 percent, which many elderly people considered to be the most important service) and 75 percent use no service at all. Not even among the old-old and the handicapped does any convincing majority use these services (Daatland & Sundstrom, 1985). Again, it is difficult to assess levels in the United States, but they are definitely higher than here, except possibly for meals-on-wheels (1 percent in Sweden).

Of course, the fact that a minority use the public services partly is the natural outcome of using cross-sectional evidence, and partly the result of having no need for the service. Yet, there is a risk that cutbacks will primarily hit the most vulnerable and those among the old who lack family or others to fend for them. These have always been in

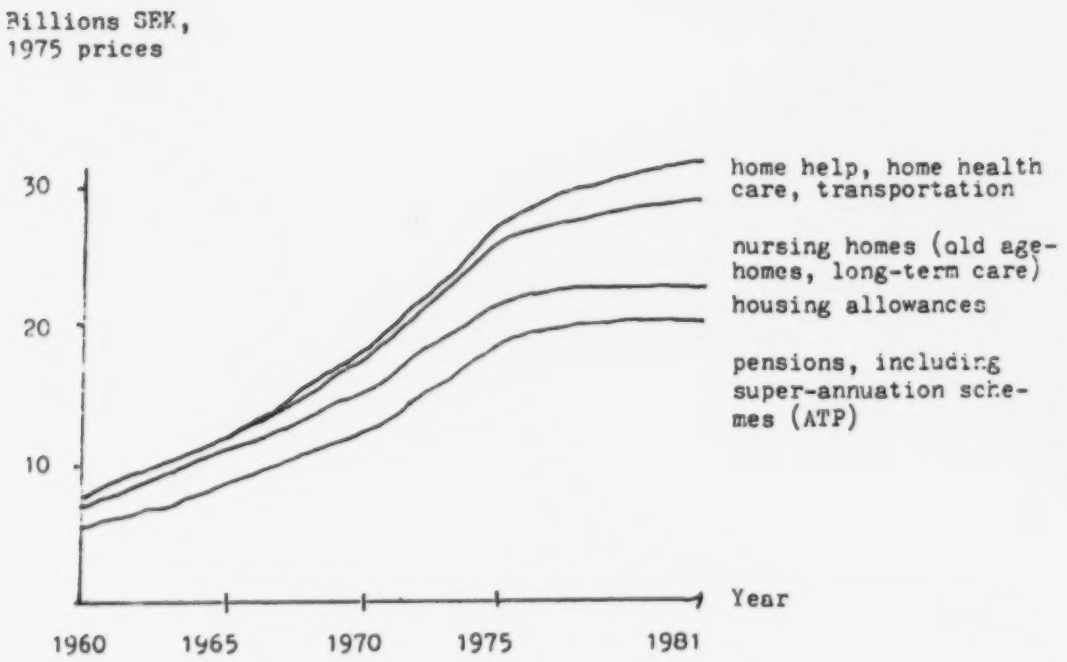
greater risk of ending up in the least desired settings, and it is important to feel pride about the advances made in the field to defend them.

Figure 1. Social costs as a percentage of Gross National Product, the Nordic countries and the United States, 1950 - 1978 (1982).



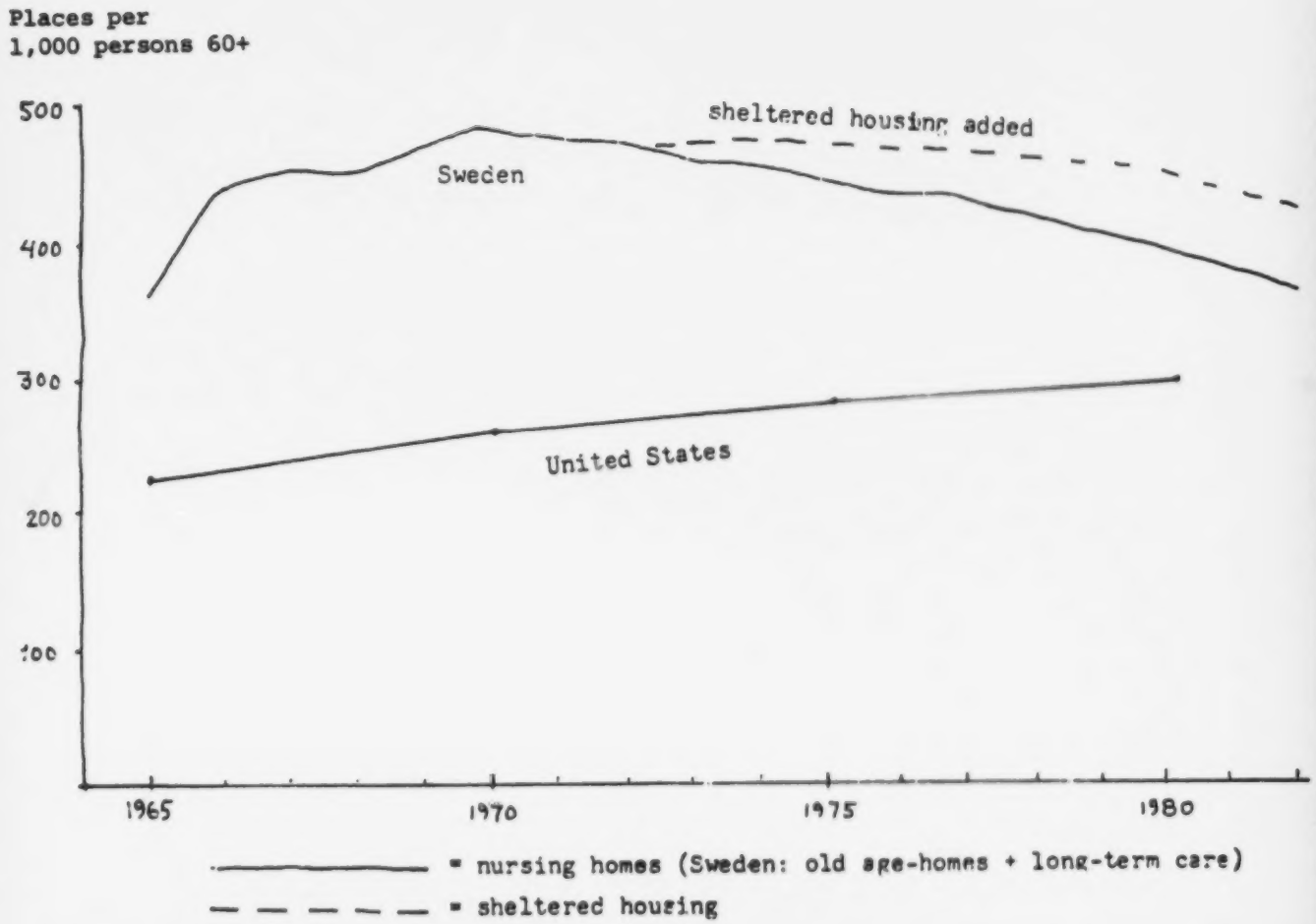
Sources: The Nordic countries - Social trygghet i de nordiska länderna 1978, Nordisk statistisk skriftserie, Stockholm 1980. Data from 1982 for Sweden from National Accounts (Statistical Yearbook of Sweden). Data for the United States from The Cost of Social Security, ILO, 1978 & 1985 (my own calculations).

Figure 2. Costs of old age-care in Sweden, 1960-1981, in 1975 prices (billions Swedish crowns).



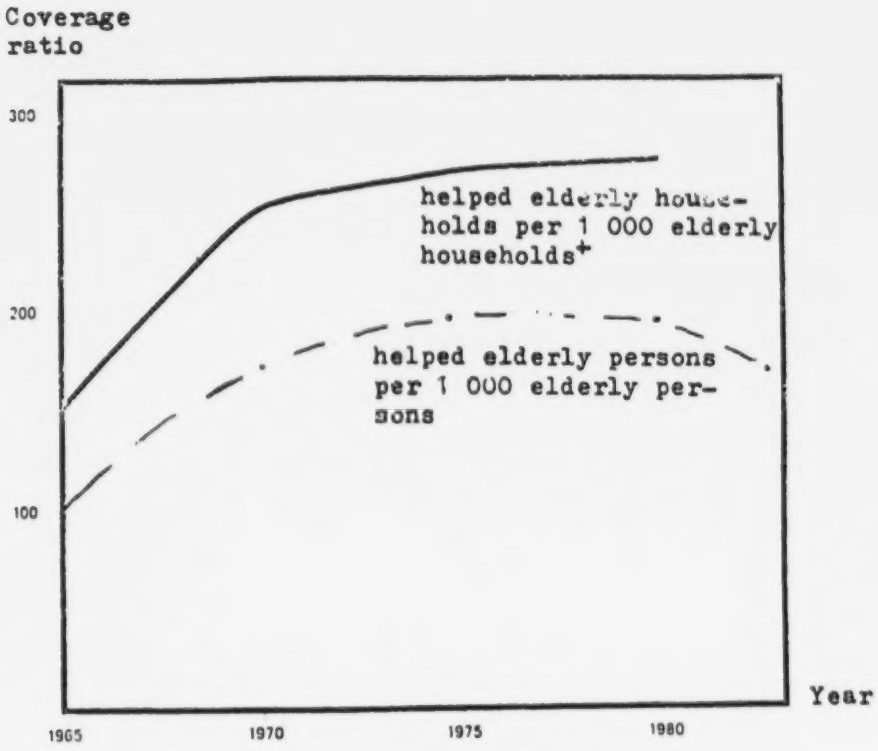
Sources: for 1960 - 1975, data in SOU 1977:98 p. 138. For 1981, data in Spri rapport 164 1983: Äldreomsorg och ekonomi, Table 3:2 with explanations in Appendix (recalculated by me with price index to refer to 1981). Information on pensions and housing allowances derive from SOS Allman försäkring mm 1981.

Figure 3. Places in nursing homes per 1 000 persons 80 and above in the population, Sweden and the United States, 1965 - 1980 (1982).



Sources: For Sweden, data collected in Daatland & Sundstrom, 1985.
For the United States, straight-line interpolations (definitions vary slightly between years) of number of beds in nursing homes indicated in NCHS (1973) p. 385 for 1963 and intermediate years in Statistical Abstract for the United States. Population figures for 1960, 1970 and 1980 are from US Census 1980, General Population Characteristics, PC 80-1-B1 US Summary, likewise interpolated for intermediate years (1965, 1970, 1975, 1980).

Figure 4. Home help coverage in Sweden, 1965 - 1982



+ regardless of who is head of the household (some elderly households being headed by younger persons).

Source: revision of data in Daatland & Sundström op.cit.

Table 1. Frequencies of institutionalization among the aged in Denmark, Norway, and Sweden, by age, 1970 - 1982, estimated figures.

	Younger old 65 - 79			Old-old 80+		
	Denmark	Norway	Sweden	Denmark	Norway	Sweden
1970	2.8	2.9	3.7	20.4	20.1	27.4
1975	2.7	2.7	3.2	22.4	20.9	26.8
1980	2.5	2.7	2.7	21.4	21.8	25.0
1982	2.4	2.5	2.4	20.5	21.8	24.6

Source: Svein Olav Daatland & Gerdt Sundström: Gammal i Norden /Old Age in the Nordic Countries/, Nordic Council of Ministers, Stockholm 1985

Note: data derive both from computations on patient stocks and from special surveys in these countries; though not absolutely uniform, the trends should be correctly depicted.

Table 2. Old people in institutions and group-quarters, by age and sex, Sweden and the United States, 1975

	Age			
	65+		75+	
	Men	Women	Men	Women
Sweden				
Number	15 672	27 947	12 548	24 906
Percent	2.8	4.0	6.6	8.8
United States				
Number 1000s	1 290	4 718	567	2 160
Percent	4.4	5.6	7.4	10.0

Sources: Sweden - Folk- och Bostadsräkningen 1975 Del 5:2 Table 1
The United States - Jacob Siegel: Demography of Aging and the Older Population of the United States, Current Population Reports, Special Studies, Series P 23 No 59, Washington D.C., United States Department of Commerce, 1978 (revised).

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FORMAL AND INFORMAL SUPPORT OF THE ELDERLY: SELECTED AMERICAN CULTURAL VALUES AND SOCIAL WELFARE POLICY

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FORMAL AND INFORMAL SUPPORT OF THE ELDERLY: SELECTED AMERICAN CULTURAL VALUES AND SOCIAL WELFARE POLICY

Larry C. Mullins

INTRODUCTION

In any discussion of the support provided for the elderly one issue must be considered immediately: the distinction between underlying assumptions guiding the development of support for the elderly, and the actual supports or services which are provided. Clearly these two issues are interrelated. Even so, these two sides of a common coin can be conceptually distinguished. "Services" can be viewed descriptively as the actual types of services that exist, the mechanisms by which services are provided, and the impact of such services. The "antecedent assumptions" on the other hand can be viewed as the backdrop for the provided services in terms of value orientations, the social policies providing direction, and the social and psychological needs of older persons.

It is this latter issue, i.e., the antecedent value and policy assumptions, that will be examined here as a background for the presentation of a comparative research agenda to examine the impact of formal and informal support for older persons.

CONTEXTUAL BACKGROUND

Robin Williams (1959) in his now classic examination of American Society presented what is still a relevant general statement of the Major Value Orientations in the United States. In this examination Williams specifies fifteen broad value orientations ranging from humanitarian mores to efficiency and practicality. Among these fifteen major American value orientations he discusses two which are especially

relevant to the examination of specific policies and issues in formal and informal support. These two value orientations are equality and freedom.

From Williams' explication, equality can be viewed in several ways. In one sense equality concerns how individuals relate to one another. That is, do persons relate to others by superordination or subordination, or are interpersonal orientations horizontal in nature? Another approach to equality concerns specific formal rights and obligations, i.e., a minimum life-space for everyone -- a minimum of what is provided below which one can not go. Still a third approach to equality concerns substantive equality of social and economic rewards. The emphasis in this context is on equality of opportunity rather than equality of condition.

Freedom relates to behavior which is not subject to external and, above all, arbitrary constraints. A major element here is the cultural premise that the individual can more easily accept control by diffuse cultural structure, more so than control by a definite social organization. This orientation leads to individuals being viewed as relatively autonomous and concurrently responsible for their own behavior and condition.

Examining these two Value Orientations one can see that much of the approach to social welfare policy in the United States could be examined within this context. Robert Morris provides a good background for this contention in his article "Social Welfare Policy and Aging: Implications for the Future -- Between the Good Earth and Pie in the Sky" (1980). Morris briefly delineates what he refers to as "a few recurring themes" in social welfare which are confronted, recede from

popular attention, and recur persistently. These themes include among others: 1) control over one's own life and the extent of the social services persons will pay for; 2) the rights and obligations of family and support systems; 3) the issue of the quality of life.

It should not be assumed that these themes fit neatly into Williams' notions of American Value Orientations. Nevertheless, the juxtaposition of several of the themes in American social welfare policy with specific American values shows a clear consistency.

SELECTED THEMES IN SOCIAL WELFARE POLICY AND AMERICAN VALUES

"Control over one's life" is certainly a recurring theme which usually surfaces in discussions pertaining either to health, especially regarding long-term care environments in terms of older persons' control over the environment within which they reside, or it surfaces related to income assurance. Clearly this is related to Williams' delineation of freedom. Morris states: "For all persons but especially for the elderly, continued control over the conditions of one's existence probably constitutes the most powerful of all desires" (1980: p. 123). He goes on to emphasize that assurance of income and good health are perhaps the most significant of the means for retaining control over one's own affairs. Looking at income, this notion of control is an underlying rationale for the bias in American public programs in favor of cash payments to individuals, rather than direct government support for programs.

This leads further to the question of: "How much will the working adult population be prepared to pay to improve the living conditions for those who are older?" Once this is resolved the question then shifts to: How will programs be organized? That is, will they be organized in

a manner which leads to equalization -- to even levels of income, or equal opportunity, regardless of income level, for health and social services? Or, will the programs continue to be primarily for the economically disadvantaged?

Shifting from income adequacy to health adequacy, medical care, next to income, is the most important issue raised by the elderly. While it is true that the elderly in the United States have access to necessary acute medical care through the Medicare program, they still have difficulty with the problems of how to continue to live under circumstances of physical limitations and disabilities for which direct medical care offers no relief. The issue here revolves around the concern for what proportion of the health care dollar should be provided for personal care supports such as home health care, chore services, transportation services, adult day care services, and so forth, rather than for hospitalization, doctors fees and institutionalization.

In other words, if the intent of policies and the programs that evolve from these policies is to facilitate personal control (qua "freedom") then by assumption a greater proportion of support should be directed to the financing of concrete social and noninstitutional health care supports. In the United States to date there has been no social support system to parallel the medical system in the care of the elderly. Social supports, at this point, must be legitimated based primarily on their relevancy to medical care.

The above issues concern the value Williams calls freedom. However, there are other themes with their attendant value orientations which must be considered. Primary among these themes is a consideration of the rights and obligations of family members and informal support

systems as distinct from the obligations of governmental and quasi-governmental agencies. It is here that the value orientation of equality most clearly surfaces.

The importance of family concerning their involvement and responsibility does not seem to have declined in contemporary American society (Bengston & Deterre, 1980; Troll, Miller & Atchley, 1979; Shanas, 1979; Streib and Beck, 1980). Among all relationships within the family network the relationships with adult children are most frequent. Although many elderly are able to care for their own needs until late in life, most go through a period of decline, wherein they become increasingly dependent on others. The family, particularly adult children, has traditionally assumed this function. Certainly there is ample evidence to support this contention (Brody, 1985; Cheal, 1983; Cicirelli, 1983; Hagestad, 1982; Lee & Ellithorpe, 1982; Sussman, 1976; Walker & Thompson, 1983).

It is estimated that 75-80 percent of the needs of the elderly are attended to by family members, without direct assistance from formal agencies. Thus, while there is considerable indication that families are involved with care and there is no real decline in bonds of affection, there has been a change in the absolute situation families confront (Morris, 1980).

As health has improved and life expectancy from age 65 increases, different demands are placed on relatives, especially adult children, for interaction and support. Additionally, with changing sex-role expectations and the concomitant increase of women in the labor force, "family responsibility" becomes more tenuous. The question arises: When an elderly person (i.e., parent) requires substantial physical and

personal care, what share should be assumed by the family, especially the adult children (Cantor, 1983; Zarit and Zarit, 1982; Zarit, Reeves & Back-Peterson, 1980)?

Another recurring theme in social welfare policy, according to Morris, concerns the issue of the quality of life. It is here there is the melding of the values of equality and freedom. It is here that individual choices meet, perhaps conflict, with the needs of the larger group. The quality of life in its broadest sense concerns the meaningful opportunities available to the elderly. What may be of benefit for older women may complement, or conflict, with the concerns of older men. What may be an adequate health service for the general population of elderly who are well, may not be adequate for those whose health has begun to decline. The income security level may be fine for one segment of persons, but not another segment. While we will not be explicating quality of life fully we are certainly looking at components of it.

A PROPOSAL FOR EXAMINATION

With this broad conceptual background it is becoming increasingly apparent that an examination concurrently examining the impact of the formal and informal supports for the elderly is necessary. This is, very much, a working, i.e., evolving, conceptualization. In Chart 1 a brief schema is presented of a substructure upon which other foundations can be added to form a more developed approach for analytical cross-cultural comparisons between countries.

In this scheme I have borrowed, liberally, from other researchers in terms of many of the variables. As an overview it is proposed that to adequately examine the quality of life of older persons it is

necessary to tie together a number of seemingly disparate elements all of which in some fashion could impinge upon people's quality of life within any cultural context: These elements include broadly: 1) the characteristics of the older persons themselves; 2) the formal health and social support services that are available; 3) the informal support network; 4) the older person's behavioral responses to their their life situations; 5) the older person's psychological condition.

In each of these broad areas examination of specific areas are suggested which would allow a full examination of the condition of the elderly. Chart 1 indicates suggested elements within each of the broad areas of concern. With respect to the characteristics of the older person it is necessary to consider such background issues as income, age, gender, marital status, and the number and gender of any grandchildren. Additionally, it would be necessary to consider the physical and mental health status and personality characteristics of the older person.

Among the issues of interest in regard to formal support services would be the type and extent of community-based services, e.g., transportation services, employment services, nutritional information, legal aid, adult day care, respite care, senior centers, and generally an adequate information and referral service. Also within the broad category of formal services would be the availability of in-home health and social care services such as home health services, homemaker services, or hospice. Still another facet of the more formal support system pertains to the type of housing and care arrangements that exist. Among the important concerns here would be the type and availability of both noninstitutional and institutional (health-related) housing.

Pertinent in this context would be such issues as cost, and among institutional settings such things as staffing ratios, discharge, mortality and morbidity rates.

Moving from the formal to the informal support system a whole array of issues surface. Primary among these are the relations that older persons have with their adult children. Extensive literature has emphasized in some fashion the feelings of attachment; the expectations that older people have of their adult children and conversely; the extent of affection and attachment behaviors, and interpersonal conflict; and in general the quality of the existing relationship. Similar issues could be addressed with respect to friendship associations.

In any dynamic system the various components of that system affect the individuals who are touched by the formal and informal services. In turn the individual's responses influence subsequent changes in the services provided. It is a mistake however to infer that the behavioral influence is on, or from, the elderly only. It is rather a more complicated set of influences which affect, in addition to the individual older person, the spouse, the adult children, grandchildren, other relatives, friends and associates, and the individual service providers.

All of the above mentioned elements can of course influence the psycho-social conditions of older persons. The extent and manner in which services are provided, the characteristics of the individuals, the relational considerations with family and friends, and the behavioral responses by the older persons can impact the older person's morale, life satisfaction, loneliness, depression, and general quality of life.

It is important to keep in mind that the approach and issues discussed above are not comprehensive. They are simply a suggestion of a sample of the number of complex issues that must be addressed before a more complete understanding can be achieved of the formal and informal support system and its impact on the elderly. Tying an approach such as that presented together with an understanding of the variability in basic value orientations between societies, value orientations such as equality and freedom, can provide a direction for a comparative analysis and understanding.

Chart 1. Elements of Quality of Life

CHARACTERISTICS OF OLDER PERSONS

Demographic

1. Income
2. Age
3. Sex
4. Marital Status
5. Number of children
6. Sex of Children

Health

1. Functional Health Status
2. Subjective Health Status
3. Mental Health Status

(Social) Psychology

1. Locus of Control
2. Rigidity

FORMAL SUPPORT COMPONENTS

Community Based Services

1. Information and Referral

2. Transportation

3. Nutritional Information

4. Employment

5. Legal Aid

6. Adult Day Care

7. Respite Care

8. Senior Center Services

In-Home Services

1. Home Health Services

2. Homemaker Services

3. Visiting and Telephone Reassurance

4. Home Delivered Meals

5. Hospice (Death Preparation)

Congregate Housing and Institutional Care

1. Types of Living and Health Care Arrangements

2. Staffing of Facilities

3. Discharge Rate

4. Mortality Rate

5. Morbidity Rate

6. Cost of Services

INFORMAL SUPPORT ISSUES

Older Parent and Adult Child and Friendship Associations

1. Feelings of Attachment

2. Parent's Expectations of Adult Children

3. Adult Children's Sense of Responsibility for Parent

4. Attachment Behaviors (Proximity, Frequency of Contact, etc.)

5. Affection

6. Interpersonal Conflict

7. Negative Feelings

8. Consensus

9. Communications

10. Quality of Relationship

11. Burden of Parent

12. Satisfaction with Living Environment

BEHAVIORAL OUTCOMES

1. Self

2. Spouse

3. Adult Children

4. Other Relatives

5. Non-Relatives

6. Formal Care Service Providers (and Services Provided)

PSYCHO-SOCIAL OUTCOMES

Of Older Person

1. Morale

2. Life Satisfaction

3. Loneliness

4. Depression

5. Quality of Life

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CARING FOR THE ELDERLY IN SWEDEN AND THE UNITED STATES

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INTRODUCTION

As an introduction, the American and the Swedish meaning of the value concepts "equality" and "freedom" will be compared, using the Swedish Social Service Act to reflect the Swedish value system. Next let us examine how the values and the legislation affect formal and informal support. Additionally, based on the findings from a study of progress concerned with the old-old's formal and informal support systems, the Swedish situation can be better understood.

Equality. Historically the most common criteria for distributing limited resources like social services, funds, personal, and time, have been the principles of equality, need, contribution, and compensation. These principles have been subject to varying translations. In the United States the principle of equality is interpreted to mean equality of opportunities, such that resources or services are made available to all on a first come, first served basis. In Sweden the extent of one's current need is the primary determinant, with equality being the outcome of the satisfaction of the identified needs. The outcome of the distributed resources should promote equality in conditions. The aim towards equality in living-conditions is emphasized in Section 1 of the Social Service Act.

> Public social services are to be established on a basis of democracy and solidarity, with a view to promoting economic and social security, equality of living conditions and active participation in the life of the community (Ministry of Health and Social Affairs, 1977).

Freedom. Professor Mullins has referred to freedom as related to behavior which is not subject to external constraints. The individual is responsible for his or her own behavior and condition. Freedom is also described as independence or control over one's own affairs where income and good health are the most significant of the means for retaining this control.

SWEDISH AND AMERICAN DIFFERENCES

A main difference between the American and Swedish concepts of the question is: Where does the responsibility lie? In the United States the individual is responsible for his or her own condition, in Sweden a considerable part of the responsibility rests upon the community. Regarding the elderly, in Section 19 of the Social Service Act it is stated:

> The social welfare committee shall endeavor to ensure that elderly persons are enabled to live independently and to enjoy active and meaningful lives together with others (1977).

The social services, the pension system and the health services aim to assure the individual enough resources to retain an independent life. So, what has the Swedish system brought about in the matter of formal and informal support? The Social Service Act states in section 6:

> The individual is entitled to assistance from the social welfare committee towards his livelihood and other aspects of living if his need cannot be provided in any other way (1977).

Regarding support for the elderly, "in any other way" legally does not mean informal support, but may in practice. There are no legal filial responsibilities but in some instances the informal support actually received is taken into account when the social worker establishes

the need for assistance. Nevertheless, the legal responsibility rests upon the individual and the formal support system.

EXAMPLES FROM AN ON-GOING STUDY

With this background, let me use the findings from my study concerned with old-old people's formal and informal support systems to examine what Swedish legislation and the Swedish cultural value system have brought about in real life.

The study involved 115 persons 80 years old and older, living independently in one neighborhood in Stockholm. Through frequent interviews with them and with the persons giving them support, data collection will continue during a 4-5 year period. The primary issue under review concerns how increasing need of support is satisfied or not satisfied by family, friends, neighbors and homemakers service, and how the systems are linked together over time. In 1985 the study had been conducted for one year with interviews with 70 older persons (some of them 2 or 3 times). Additionally, discussions with some of the support givers have been conducted but what is referred to here is mainly the elderly persons' points of view and my own observations.

The first and most important finding is that most of the respondents manage very well in their daily lives without any support from any care system. The fact is surprising. It does not correspond with what is typically pictured in various reports. It is felt that people in this age group are much more dependent on help from others. It has been stated that "of elderly pensioners 80 years or older only 8 %, and of the physically handicapped, 5 %, managed completely without help -- others are in need of help" (Ministry of Health and Social Affairs, 1977:98). The National Commission on Aging indicates "nearly 45% of people over 80

years and above receive help from relatives, friends and acquaintances at least once a week and nearly every third pensioner receives daily help" (1982).

This picture of the elderly as dependent persons does not correspond with what I have observed, though a distinction between physical help and emotional support must be made. Except one small group, i.e., the married couples, the elderly person who receives physical help mainly receives it from the homemakers service. In the neighborhood under study, 45% of this age group have a social home-helper, the same as the overall Swedish average. Speculatively, perhaps the other 55% received physical help from the informal systems. However, this has not been the case (other than occasionally). These elderly, however, thought they would get this help if necessary.

Emotional support, on the other hand, is mainly given by the informal systems. Because the elderly receive the physical support they need from the social and medical services, they do not feel they are a burden to the family. They think the pleasure of interaction with family and friends is mutual.

The neighborhood is 30 years old and many of the respondents have lived here during this entire period. They know their neighbors and have considerable interaction with them, including those younger than themselves. The neighbors sometimes replace old friends that passed away and although not much physical help is exchanged the elderly feel they can trust the neighbors in case of emergency.

The most common pattern of interaction between the elderly and their children is that they meet once a week and talk on the phone every day. The main filial responsibility is to keep in touch to see that everything

is all right. Among the old persons who do not have a home-helper, it is more common for the elderly to give support to the child than vice versa. As an example, one 86 year old woman cleans her daughter's house every week, including the windows if necessary, and also brings freshly baked bread. The daughter has a full-time job. This old woman also plays bridge 3 times a week and the rest of the time she works on writing her memoirs. But it is more common for the old people and their children to meet on weekends, have dinner together or some other activity. Sometimes the children help with paperwork and contacts with authorities.

There seems to be no great difference in health between those who have home-helper services and those who do not. I have found the same degree of functional decline in both groups, but there is an obvious difference in self-reliance in terms of what the person can or cannot manage.

Those who receive formal physical help also get more informal help. It is unclear if it is the old person who wants all this help or if it is the support-giver's decision. Nevertheless, those few who receive long term physical help from both systems feel they do not have much control over their own lives.

As an example, one 80 year old widower has a daughter who visits him every day after work to cook his dinner. A home-helper comes 3 times a week. The man is in good health but he indicates he spends most of his day lying on the couch or looking out the window. The daughter and the social worker in charge of the home-helpers decide what he needs and they fulfill these needs.

SUMMARY AND CONCLUDING REMARKS

In sum, it should be emphasized that most of the elderly people in this population, 80 years old and above who live independently, indicate they take care of themselves, and they live a satisfactory life without help from either formal or informal support systems, but in close interaction with family and neighbors.

Physical help is provided to those who need it and want it from the social services. The elderly believe they live an independent life with this help and with the transportation service (which enables them to visit their family and obtain medical services).

What emerges is a bright picture of the life of the old-old people in this neighborhood. This is true, for the most part. However to get the benefit from the support systems, to enjoy the equality and the Swedish concept of freedom, one must accept formal help and accept that your needs to some extent are defined by a social worker. One must accept that another person comes into your home and deals with your personal belongings. But this other person sometimes is viewed as a formal supervisor. Some of the elderly indicate they will never let anybody into their homes. They would rather life a more limited life with a pride in the fact they manage by themselves. Maybe they feel "the American way" about freedom.

As long as they do manage by themselves it is fine, but what will happen when they cannot manage any longer? This is one question which deserves more discussion. Other pertinent questions concern such issues as the following: As the formal homemaker service is not developed to the same extent in the U.S.A., does this mean the elderly receive more

physical help from the informal system? If so, how does it affect the relationship between the elderly and their informal support systems?

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